Supplement to:
RY2009 EOHHS Technical Specifications Manual
for Appendix G Measures Reporting (2.1)

Appendix A-12:

Data Dictionary for Maternity Measures (MAT-1 and MAT-2)

Maternity Measures (MAT-1 and MAT-2) Data Dictionary
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Data Dictionary Notes:

- Underlined text in version 2.1 indicates an update has been inserted.
- Bold italic font reflect updates in version 2.0 that did not change.

Data Element Name: *Admission Date*

Collected For: All MassHealth Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

Allowable Values:

MM =	Month (01-12)
DD =	Day (01-31)
YYYY =	Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the admission date on the claim information.

A patient of a hospital is considered an inpatient upon issuance of written doctors orders to that effect.

Clarification for 04/01/2008 discharges
For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.

Suggested Data Sources: Face sheet
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name: *Admission Source*

Collected For: All MassHealth Records

Definition: The source of inpatient admission for the patient.

Suggested Data Collection Question: What was the source of inpatient admission for the patient?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Non-Health Care Facility Point of Origin
The patient was admitted to this facility upon order of a physician.
Usage Note: Includes patients coming from home, a physician's office, or workplace

2 Clinic
The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.

3 Reserved for assignment by the NUBC
(Discontinued effective 10/1/2007.)

4 Transfer From a Hospital (Different Facility)
The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.
Usage Note: Excludes transfers from Hospital Inpatient in the same facility (See Code D).

5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6 Transfer from another Health Care Facility
The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.

7 Emergency Room
The patient was admitted to this facility after receiving services in this facility's emergency room.
Usage Note: **Excludes** patients who came to the emergency room from another health care facility.

8 Court/Law Enforcement
The patient was admitted to this facility upon the direction of court of law, or upon the request of a law enforcement agency.
Usage Note: Includes transfers from incarceration facilities.

9 Information not Available
The means by which the patient was admitted to this hospital is unknown.

Allowable Values: continued

A Reserved for assignment by the NUBC. (Discontinued effective 10/1/2007.)

D Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer
The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer.
Usage Note: For purposes of this code, "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.

E Transfer from Ambulatory Surgery Center
The patient was admitted to this facility as a transfer from an ambulatory surgery center.

F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program
The patient was admitted to this facility as a transfer from hospice.

Notes for Abstraction:

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the admission source is correct. If the abstractor determines through chart review that the admission source is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the admission date on the claim information.

If unable to determine admission source, select "9."

Suggested Data Sources:

Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	If the patient was transferred from an emergency department of another hospital, do not use "7." This is only for patients admitted upon recommendation of **this** facility's emergency department physician/advanced practice nurse/physician assistant (physician/APN/PA).

Data Element Name: *Admission Time*

Collected For: MAT-1

Definition: The time (military time) of admission to the Labor and Delivery unit.

Suggested Data Collection Question: At what time was the mother admitted to the Labor and Delivery unit?

Format:
Length: 5 – HH:MM (with or without colon)
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00-23)
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight	00:00	Noon	12:00
5:31 am	05:31	5:31 pm	17:31
11:59 am	11:59	11:59 pm	23:59

Notes for Abstraction: ***Time must be abstracted in military time format.***

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Amniotic Membrane Rupture 18 or More Hours*

Collected For: MAT-1

Definition: Documentation of amniotic membranes rupture for 18 or more hours.

Suggested Data Collection Question: Is there documentation that the amniotic membranes were ruptured for 18 or more hours?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the amniotic membranes were ruptured for 18 hours or longer.
N (No)	There is no documentation that the amniotic membranes were ruptured for 18 hours or longer OR duration of amniotic membrane rupture cannot be determined from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources: History and physical
Nursing notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Administration Date (MAT-1)*

Collected For: MAT-1

Definition: The date (month, date, and year) the IV antibiotic for intrapartum GBS prophylaxis was administered.

Suggested Data Collection Question: On what date was the IV antibiotic for intrapartum GBS prophylaxis administered?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (0-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: If the intrapartum prophylactic IV antibiotic was administered on multiple occasions, abstract the first date of administration.

Suggested Data Sources:
IV flowsheets
Medication administration record (MAR)
Nursing notes
Physician notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Administration Date (MAT-2)*

Collected For: MAT-2

Definition: The date (month, day, and year) the IV antibiotic for Cesarean section surgical prophylaxis was administered.

Suggested Data Collection Question: On what date was the IV antibiotic for Cesarean section surgical prophylaxis administered?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (0-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: The IV antibiotic administration time frame for the MAT-2 measure is one hour prior to Cesarean section incision time up to five minutes after the time of delivery. Abstract the administration date that falls within this timeframe.

Suggested Data Sources:
Anesthesia record
Delivery note
IV flowsheets
Medication administration record (MAR)
Nursing notes
Operating room record
Physician notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Administration Time (MAT-1)*

Collected For: MAT-1

Definition: The time (military time) the IV antibiotic for intrapartum prophylaxis for GBS was administered.

Suggested Data Collection Question: At what time was the IV antibiotic for intrapartum GBS prophylaxis administered?

Format:
Length: 5 – HH:MM (with or without colon)
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00-23)
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight	00:00	Noon	12:00
5:31 am	05:31	5:31 pm	17:31
11:59 am	11:59	11:59 pm	23:59

Notes for Abstraction: When collecting the time of administration of an antibiotic administered via infusion (IV), Antibiotic Administration Time refers to the time the antibiotic infusion was started.

If an intrapartum IV prophylactic antibiotic was administered on multiple occasions, record the first time of administration.

If multiple administration times are documented for the first dose given, abstract the time recorded by the clinician administering the drug. If it is unclear who administered the drug, abstract the earliest time documented for that dose.

Suggested Data Sources: IV flowsheets
Medication administration record (MAR)
Nursing notes
Physician notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Administration Time (MAT-2)*

Collected For: MAT-2

Definition: The time (military time) the IV antibiotic for Cesarean section surgical prophylaxis was administered.

Suggested Data Collection Question: At what time was the IV antibiotic for Cesarean section surgical prophylaxis administered?

Format:
Length: 5 – HH:MM (with or without colon)
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00-23)
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight	00:00	Noon	12:00
5:31 am	05:31	5:31 pm	17:31
11:59 am	11:59	11:59 pm	23:59

Notes for Abstraction: When collecting the time of administration of an antibiotic administered via infusion (IV), Antibiotic Administration Time refers to the time the antibiotic infusion was started.

The IV antibiotic administration time frame for the MAT-2 measure is one hour prior to Cesarean section incision time up to ***five minutes after*** the time of delivery. Abstract the administration time that falls within this timeframe.

If multiple administration times are documented for the prophylactic perioperative antibiotic, abstract the time recorded by the clinician administering the drug. If it is unclear who administered the drug, abstract the earliest time documented for that dose.

If the only documentation of antibiotic timing in the medical record indicates the intravenous antibiotic was given at cord clamp, abstract cord clamp time as the time of administration. If cord clamp time is not recorded, abstract delivery time for this data element.

Suggested Data Sources:
Anesthesia record
Delivery note
IV flowsheets
Medication administration record (MAR)
Nursing Notes
Operating room record
Physician notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Name for Cesarean Section Prophylaxis*

Collected For: MAT-2

Definition: The name of the IV antibiotic administered for Cesarean section surgical prophylaxis.

Suggested Data Collection Question: What is the antibiotic name of the IV antibiotic administered for Cesarean section surgical prophylaxis?

Format:
Length: 244
Type: Alpha
Occurs: 1

Allowable Values:
Ampicillin
Cefazolin
Gentamycin
Other

Notes for Abstraction: ***Data is collected on one antibiotic administered within the targeted time frame, within one (1) hour prior to surgical incision up to five (5) minutes after the time of delivery.***

Only the allowable values should be abstracted. For a crosswalk for Trade and Generic Names, consult Table 2.1 of Appendix C of the NHQM Specifications Manual.

A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered.

Suggested Data Sources:
Anesthesia record
IV flowsheet
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Nursing notes
Operative report
Operating room record
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Name for GBS Prophylaxis*

Collected For: MAT-1

Definition: The name of the IV antibiotic administered for GBS prophylaxis.

Suggested Data Collection Question: What is the name of the IV antibiotic administered for GBS prophylaxis?

Format:
Length: 244
Type: Alpha
Occurs: 1

Allowable Values:
Ampicillin
Cefazolin
Clindamycin
Erythromycin
Penicillin
Vancomycin
Other

Notes for Abstraction: ***Data is collected only on the first administration of the intrapartum prophylactic antibiotic for GBS.***

Only the allowable values should be abstracted. For a crosswalk for Trade and Generic Names, consult Table 2.1 of Appendix C of the NHQM Specifications Manual.

A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered.

Suggested Data Sources:
Delivery room record
IV flowsheet
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Nursing notes
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Antibiotic Treatment for Prophylaxis within 24 Hours*

Collected For: MAT-2

Definition: Documentation that the patient received IV antibiotic treatment for prophylaxis within 24 hours prior to surgery.

Suggested Data Collection Question: Is there documentation that the patient received IV antibiotic treatment for prophylaxis within 24 hours prior to surgery?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

A Yes, there is documentation that the patient received IV antibiotic treatment for GBS prophylaxis within 24 hours prior to surgery.

B Yes, there is documentation that the patient received IV antibiotic treatment for prophylaxis other than GBS within 24 hours prior to surgery.

C No, there is no documentation that the patient received IV antibiotic prophylaxis or unable to determine from medical record documentation.

Notes for Abstraction: This question refers to IV antibiotic treatment for prophylaxis for reasons other than surgical prophylaxis, (e.g. GBS, chorioamnionitis, bacterial endocarditis).

A physician order alone is not sufficient to abstract this data, there must also be documentation that the medication was administered.

Suggested Data Sources: Medication administration record (MAR)
Physician notes
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Birthdate*

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate.* The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age**.**

Suggested Data Collection Question: What is the patient's date of birth?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Case Identifier*

Collected For: All MassHealth Records

Definition: A measurement system-generated number that uniquely identifies an episode of care. This identification number should be used by the performance measurement system in order to allow the health care organization to link this Case Identifier to a specific episode of care.

Suggested Data Collection Question: What is the unique measurement system-generated number that identifies this episode of care?

Format:
Length: 9
Type: Numeric
Occurs: 1

Allowable Values: Values greater than zero (0) assigned by the system.

Notes for Abstraction: None

Suggested Data Sources: Unique measurement system generated number

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Cesarean Section Incision Time*

Collected For: MAT-2

Definition: The time (military time) the initial incision was made for the Cesarean section procedure.

Suggested Data Collection Question: At what time was the initial incision made for the Cesarean section procedure?

Format:
Length: 5 – HH:MM (with or without colon)
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00-23)
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight	00:00	Noon	12:00
5:31 am	05:31	5:31 pm	17:31
11:59 am	11:59	11:59 pm	23:59

Notes for Abstraction: ***Follow the priority order below. If multiple times are found, abstract the earliest time found within the highest priority grouping.***

First Priority: Incision Time

- ***Skin time***
- ***Symbol used on grid and indicated on legend to be incision time***

Second Priority: Surgery Start / Begin Time

- ***Begin time***
- ***Case start time***
- ***Operation opened***
- ***Operation start time***
- ***Procedure start time***
- ***Surgery start time***

Third priority: Anesthesia Time

- ***Anesthesia begin time***
- ***Anesthesia induction time***
- ***Anesthesia opened***
- ***Anesthesia start time***
- ***Anesthesia time***
- ***Induction complete time operating room start time***

Notes for Abstraction: continued

Example #1: If surgery start time is documented at 10:05 and skin time is documented at 10:10, abstract 10:10 for the data element Cesarean Section Incision Time since skin time is related to incision time, the first priority.

Example #2: If documentation of 15:10 for anesthesia opened and 15:20 for anesthesia start time are found in the medical record, abstract 15:10 for the data element Cesarean Section Incision Time since this is the earliest time found within the third priority, anesthesia time.

Suggested Data Sources:

Anesthesia record
Circulation record
Nursing notes
Operative report
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Cesarean Section Start Date*

Collected For: MAT-2

Definition: The date (month, day, and year) the Cesarean section procedure started.

Suggested Data Collection Question: On what date did the Cesarean section procedure start?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: None

Suggested Data Sources:
Anesthesia record
Circulation record
Nursing notes
Operative report
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Clinical Trial*

Collected For: All MassHealth Records

Definition: Documentation that the patient was involved in a clinical trial during this hospital stay, relevant to the measure set for this admission. Clinical trials are organized studies to provide large bodies of clinical data for strategically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

Suggested Data Collection Question: Is the patient participating in a clinical trial?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission.
N (No)	There is no documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission or unable to determine from medical record documentation.

Notes for Abstraction: This data element is used to exclude patients that are involved in a clinical trial during this hospital stay relevant to the measure set for this admission. Consider the patient involved in a clinical trail if documentation indicates:

- The patient was evaluated for enrollment in a clinical trial after hospital arrival, but was not accepted or refused participation.
- The patient was newly enrolled in a clinical trial during the hospital stay.
- The patient was enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during the hospital stay.
- To answer "Yes" to this data element, there must be formal documentation (trial protocol or patient consent form) in the medical record that the patient was involved in a clinical trial designed to enroll patients with the condition specified in the applicable measure set.
- If it is not clear which study that the clinical trial is enrolling, select "No". Assumptions should not be made if it is not specified.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**

- Clinical trial protocol
- Consent forms for clinical trial

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Delivery Date (MAT-1)*

Collected For: MAT-1

Definition: The month, day, and year the baby was delivered.

Suggested Data Collection Question: On what date was the infant delivered?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

Allowable Values:

MM =	Month (0-12)
DD =	Day (01-31)
YYYY =	Year (2000 – 9999)

Notes for Abstraction: If there are multiple births, abstract data on the infant born first.

Suggested Data Sources:
Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Delivery Date (MAT-2)*

Collected For: MAT-2

Definition: The month, day, and year the baby was delivered.

Suggested Data Collection Question: On what date was the infant delivered?

Format:

Length:	10 – MM-DD-YYYY (includes dashes)
Type:	Date
Occurs:	1

Allowable Values:

MM =	Month (0-12)
DD =	Day (01-31)
YYYY =	Year (2000 – 9999)

Notes for Abstraction: If there are multiple births, abstract data on the infant born last.

Suggested Data Sources:
Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Delivery Time (MAT-1)*

Collected For: MAT-1

Definition: The time (military time) the baby was delivered.

Suggested Data Collection Question: At what time was the infant delivered?

Format:
Length: 5 – HH:MM (with or without colon)
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00-23)
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight	00:00	Noon	12:00
5:31 am	05:31	5:31 pm	17:31
11:59 am	11:59	11:59 pm	23:59

Notes for Abstraction: If there are multiple births, abstract data on the infant born first.

Suggested Data Sources:
Birth Certificate
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Delivery Time (MAT-2)*

Collected For: MAT-2

Definition: The time (military time) the baby was delivered.

Suggested Data Collection Question: At what time was the infant delivered?

Format:
Length: 5 – HH:MM (with or without colon)
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00-23)
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a four digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight	00:00	Noon	12:00
5:31 am	05:31	5:31 pm	17:31
11:59 am	11:59	11:59 pm	23:59

Notes for Abstraction: If there are multiple births, abstract data on the infant born last.

Delivery time is collected for the MAT-2 measure as a proxy for cord clamping. A period of five minutes will be added to the delivery time to allow for cord clamping. Appropriate IV prophylaxis time frame will include one (1) hour prior to delivery up to five (5) minutes after delivery time to allow for cord clamping.

Suggested Data Sources: Birth Certificate
Delivery note
Discharge summary
Labor and delivery summary
Nursing notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Discharge Date*

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Transfer note

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Discharge Status*

Collected For: All MassHealth Records

Definition: The place or setting to which the patient was discharged.

Suggested Data Collection Question: What was the patient's discharge disposition?

Format:
Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:

01 Discharge to home care or self care (routine discharge)
Usage Note: Includes discharge to home; jail or law enforcement; home on oxygen if DMS only; any other DMS only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 Discharged / transferred to a short to a short term general hospital for inpatient care

03 Discharged / transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
Usage Note: Medicare indicates that the patient is discharged / transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61 – Swing Bed. For reporting other discharges / transfers to nursing facilities, see 04 and 64.

04 Discharged / transferred to an intermediate care facility (ICF)
Usage Note: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged / transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges / transfers to state designated Assisted Living facilities.

05 ***For discharges 01/01/2008 through 09/30/2008***
Discharged / transferred to another type of health acre institution not defined elsewhere in this code list
Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

05 Effective with 10/01/2008 discharges
Discharged/transferred to a designated cancer center or children's hospital
Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html

Allowable Values continued:

06 Discharge / transferred to home under care of organized home health service organization in anticipation of covered skilled care
Usage Note: Report this code when the patient is discharged / transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services.

07 Left against medical advice or discontinued care

20 Expired

41 ***For discharges 01/01/2008 through 09/30/2008***
Expired in a medical facility (e.g., hospital, SNF, ICF or freestanding hospice)
Usage Note: For use only on Medicare and CHAMPUS (TRICARE) claims for hospice care.

43 Discharged/transferred to a federal health care facility
Usage Note: Discharges and transfers to a government Operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

50 Hospice – home

51 Hospice - medical facility (certified) providing hospice level of care

61 Discharged/transferred to hospital-based Medicare approved swing bed
Usage Note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within a hospital's approved swing bed arrangement.

62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
Usage Note: For hospitals that meet the Medicare criteria forLTCH certification.

64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66 Discharged/transferred to a Critical Access Hospital (CAH)

70 Effective with 10/01/2008 discharges
Discharged/transferred to another type of health care institution not defined elsewhere in this code list (See Code 05)

Notes for Abstraction: The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by billing/HIM to complete the UB-04.

Because this data element is critical in determining the population for many measures, the abstractor should **not** assume that the claim information for discharge status is correct. If the abstractor determines through chart review that the discharge status is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge status through chart review, she/he should default to the discharge status on the claim information.

Suggested Data Sources:
Discharge instruction sheet
Discharge summary
Face sheet
Nursing discharge notes
Physician orders
Progress notes
Social service notes
Transfer record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 2.5 in the Specifications Manual for National Hospital Quality Measures.	None

Data Element Name: *Episode of Care*

Collected For: All MassHealth Records

Definition: The code for the measure set submitted.

Suggested Data Collection Question: What is the measure set for which data is being submitted?

Format:

Length:	22
Type:	Alphanumeric
Occurs:	1

Allowable Values:

CAC-1a	Inpatient Use of Relievers
CAC-2a	Inpatient Use of Corticosteroids
MAT-1	Intrapartum Antibiotic Prophlyaxis for GBS
MAT-2	Perioperative Antibiotics for Cesarean Section
NICU-1	Administration of Antenatal Steroids
PN	Community Acquired Pneumonia
SCIP	Surgical Care Infection Prevention

Notes for Abstraction: None.

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Ethnicity (DHCFP)*

Collected For: All MassHealth Records

Definition: Documentation of the patient's ***self-reported*** ethnicity as defined by Massachusetts DHCFP regulations.

Suggested Data Collection Question: ***What is the patient's self-reported ethnicity?***

Format:
Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

Code	Allowable Value	Code	Allowable Value
2060-2	African	**2071-9**	Haitian
2058-6	African American	**2158-4**	Honduran
AMERCN	American	**2039-6**	Japanese
2028-9	Asian	**2040-4**	Korean
2029-7	Asian Indian	**2041-2**	Laotian
BRAZIL	Brazilian	**2148-5**	Mexican, Mexican American, Chicano
2033-9	Cambodian	**2118-8**	Middle Eastern
CVERDN	Cape Verdean	**PORTUG**	Portuguese
CARIBI	Caribbean Island	**2180-8**	Puerto Rican
2034-7	Chinese	**RUSSIA**	Russian
2169-1	Columbian	**2161-8**	Salvadoran
2182-4	Cuban	**2047-9**	Vietnamese
2184-0	Dominican	**2155-0**	Central American (not specified)
EASTEU	Eastern European	**2165-9**	South American (not specified)
2108-9	European	**OTHER**	Other Ethnicity
2036-2	Filipino	**UNKNOW**	Unknown/not specified
2157-6	Guatemalan		

The Massachusetts DHCFP codes and allowable values for ethnicity listed above differ significantly from ones required for National Hospital Quality Measures reporting. Hospitals must use the DHCFP ethnicity codes and allowable valuables when preparing all MassHealth data files for submission.

Notes for Abstraction: ***Only collect ethnicity data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.***

If numeric code is used, include the hyphen after the fourth number.

If the medical record contains conflicting documentation on patient self-reported ethnicity, abstract the most recent dated documentation.

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the DHCFP requirements must be provided for chart validation.

Suggested Data Sources: ***Administrative record***
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *First Name*

Collected For: All MassHealth Records

Definition: The patient's first name.

Suggested Data Collection Question: What is the patient's first name?

Format:
Length: 30
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *GBS Bacteriuria*

Collected For: MAT-1

Definition: Documentation that the mother had GBS bacteriuria during this pregnancy.

Suggested Data Collection Question: Is there documentation that the mother had GBS bacteriuria during this pregnancy?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the mother had GBS bacteriuria during this pregnancy.
N (No)	There is no documentation that the mother had GBS bacteriuria during this pregnancy or unable to determine from medical record documentation.

Notes for Abstraction: GBS Bacteriuria must be documented for the current pregnancy

Suggested Data Sources: History and physical
Pre-natal record
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *GBS Screening*

Collected For: MAT-1

Definition: Documentation of results of the mother's vaginal and rectal screening culture for GBS at 35 – 37 weeks.

Suggested Data Collection Question: What is the result of the mother's vaginal and rectal screening culture for GBS at 35 – 37 weeks?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

P Positive: there is documentation that the mother's vaginal and rectal screening culture for GBS at 35 – 37 weeks was positive.

N Negative: there is documentation that the mother's vaginal and rectal screening culture for GBS at 35 – 37 weeks was negative.

U Unknown / Unable to Determine: there is no documentation of the results of the mother's vaginal and rectal screening culture for GBS at 35 – 37 weeks or unable to determine from medical record documentation.

Notes for Abstraction: Documentation must state that the screening culture was performed between the 35th and 37th week of pregnancy.

If delivery occurs prior to 35 weeks gestation, abstract "U" for this data element.

Suggested Data Sources:
Delivery note
History and physical
Lab reports
Labor and delivery flow sheets
Labor and delivery summary
Prenatal record
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Gestational Age*

Collected For: MAT-1

Definition: The gestational age of the baby in completed weeks.

Suggested Data Collection Question: What was the infant's gestational age at the time of delivery?

Format:
Length: 2
Type: Numeric
Occurs: 1

Allowable Values:
In completed weeks
No leading zero

Notes for Abstraction: Use completed weeks of gestation, do not "round up"

If multiple gestational ages are documented, abstract the last gestational age documented prior to birth.

Suggested Data Sources:
Delivery note
Discharge summary
History and physical
Labor and delivery flow sheets
Labor and delivery summary
Prenatal record
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Gestational Age < 37 Weeks*

Collected For: MAT-1

Definition: A gestational age at the time of delivery less than 37 weeks.

Suggested Data Collection Question: Is there documentation that the gestational age of the infant at the time of delivery was less than 37 weeks?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the gestational age of the infant at the time of delivery was less than 37 weeks.
N (No)	There is no documentation that the gestational age of the infant at the time of delivery was less than 37 weeks or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Delivery note
History and physical
Labor and delivery flow sheets
Labor and delivery summary
Progress notes
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hispanic **Indicator** (DHCFP)*

Collected For: All MassHealth Records

Definition: Documentation that the patient self-reported as Hispanic, Latino, or Spanish.

Suggested Data Collection Question: ***Is there documentation that the patient self-reported as Hispanic, Latino, or Spanish?***

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	Patient self-reported as Hispanic / Latino / Spanish.
N (No)	Patient did not self-report as Hispanic / Latino / Spanish or unable to determine from medical record documentation.

Notes for Abstraction: ***Only collect data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.***

If the medical record contains conflicting documentation on patient self-reported Hispanic Indicator, abstract the most recent dated documentation.

Suggested Data Sources: ***Administrative records***
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusion	Exclusion
The term "Hispanic" or "Latino" can be used in addition to "Spanish origin" to include a person of Cuban, Puerto Rican, Mexican, Central or South American, or other Spanish culture or origin regardless of race.	None

Data Element Name: *Hospital Bill Number*

Collected For: All MassHealth Records

Definition: The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution as defined by Massachusetts DHCFP.

Suggested Data Collection Question: What is the patient's hospital bill number?

Format:
Length: 20
Type: Alphanumeric
Occurs: 1

Allowable Values: Values greater than zero (0) assigned by the hospital.

Notes for Abstraction: None

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hospital Patient ID Number*

Collected For: All MassHealth Records

Definition: ***The identification number used by the Hospital to identify this patient.***

Suggested Data Collection Question: What is the patient's hospital patient identification number?

Format:
Length: 40
Type: Alphanumeric
Occurs: 1

Allowable Values: Up to 40 letters and / or numbers

Notes for Abstraction: ***When abstracting this data element for a crosswalk file, the data in this field must match the hospital patient ID number submitted in the corresponding clinical measure file.***

Suggested Data Sources: ***Administrative record***
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Infection Prior to Cesarean Section*

Collected For: MAT-2

Definition: Documentation the patient had, ***or was suspected to have,*** an infection during this hospitalization prior to the Cesarean section procedure.

Suggested Data Collection Question: Is there documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is physician / advanced practice nurse (APN) / physician assistant (PA) documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section procedure.
N (No)	There is no physician / APN / PA documentation that the patient had a confirmed or suspected infection during this hospitalization prior to the Cesarean section procedure or unable to determine from medical record documentation.

Notes for Abstraction: If there is documentation of an infection or possible / suspected infection, select "Yes."

Documentation of symptoms (example: fever, elevated white blood cells, etc.) should not be considered infections unless documented as an infection or possible/suspected infection.

Patients with a principal ICD-9-CM diagnosis code suggestive of preoperative infectious diseases (as defined in Appendix A Table 5.09 of the Specifications Manual for National Hospital Quality Measures) are excluded.

Suggested Data Sources: Anesthesia record
History and physical
Progress notes

Guidelines for Abstraction:

Inclusions		Exclusions
Abscess Acute abdomen Bloodstream infection Bone infection Cellulitis Gangrene Gross/extensive fecal contamination H. pylori Lung infiltrates	Necrotic/ischemic/infarcted bowel Osteomyelitis Other documented infection Penetrating abdominal trauma Pneumonia or other lung infection Sepsis Surgical site or wound infection Urinary tract infection (UTI)	Colonized MRSA History (Hx) of MRSA Viral infections

Data Element Name: *Intrapartum Antibiotics*

Collected For: MAT-1

Definition: Documentation that the patient received IV antibiotics in the intrapartum period.

Suggested Data Collection Question: Is there documentation that the patient received IV antibiotics in the intrapartum period?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient received IV antibiotics in the intrapartum period.
N (No)	There is no documentation that the patient received IV antibiotics in the intrapartum period or unable to determine from medical record documentation.

Notes for Abstraction: Intrapartum is defined as during labor and delivery or childbirth

Suggested Data Sources:
Delivery note
Discharge summary
Labor and delivery flow sheet
Labor and delivery summary
Medication administration record (MAR)
Physician notes
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Intrapartum Temperature*

Collected For: MAT-1

Definition: Documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C).

Suggested Data Collection Question: Is there documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C)?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C).
N (No)	There is no documentation that a temperature taken on the mother during the intrapartum period was greater than or equal to 100.4 F (38.0 C) or unable to determine from medical record documentation.

Notes for Abstraction: Intrapartum is defined as during labor and delivery or childbirth

Suggested Data Sources: History and physical
Labor and delivery flow sheet
Physician notes
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *IV Antibiotic for Cesarean Section Prophylaxis*

Collected For: MAT-2

Definition: Documentation the patient received an IV antibiotic for Cesarean section prophylaxis.

Suggested Data Collection Question: Is there documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis.
N (No)	There is no documentation that the patient received an IV antibiotic for Cesarean section surgical prophylaxis or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Anesthesia record
IV flowsheet
Medication administration record (MAR)
Nursing notes
Operating room record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Last Name*

Collected For: All MassHealth Records

Definition: The patient's last name.

Suggested Data Collection Question: What is the patient's last name?

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources: Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Live Newborn*

Collected For: MAT-1

Definition: Documentation the baby delivered was born alive

Suggested Data Collection Question: Is there documentation that the mother delivered a live newborn?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the mother delivered a live newborn.
N (No)	There is documentation that the mother delivered a live newborn or unable to determine from medical record documentation.

Notes for Abstraction: In cases of multiple births and one infant is born alive, select "Yes".

Suggested Data Sources:
Birth certificate
Delivery note
Discharge summary
Nurses notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *MAT-1 Measure Eligibility*

Collected For: MAT-1

Definition: Documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-1 measure.

Suggested Data Collection Question: Is there documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-1 measure?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-1 measure.
N (No)	There is no documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-1 measure or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face Sheet
Nursing notes
Physician notes

Guidelines for Abstraction:

Inclusions	Exclusion
Refer to Appendix A, Tables 4.01 through 4.04 in the Specifications Manual for National Hospital Quality Measures for a list of valid ICD-9-CM codes.	None

Data Element Name: *MAT-2 Measure Eligibility*

Collected For: MAT-2

Definition: Documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-2 measure.

Suggested Data Collection Question: Is there documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-2 measure?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-2 measure.
N (No)	There is no documentation that the medical record has been assigned an ICD-9-CM code that meets inclusion criteria for the MAT-2 measure or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face Sheet
Nursing notes
Physician notes

Guidelines for Abstraction:

Inclusions	Exclusion
ICD-9-CM Procedure codes: 74.0 74.1 74.2 74.4 74.99	None

Data Element Name: *Maternal Allergies*

Collected For: MAT-1, MAT-2

Definition: Documentation that the patient has an allergy, sensitivity, or intolerance to penicillin, beta lactams, cephalosporins, or aminoglycosides. An allergy can be defined as an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.

Suggested Data Collection Question: Is there documentation that the patient has any allergies, sensitivities, or intolerance to beta-lactam/penicillin antibiotics, cephalosporin medications, or aminoglycosides?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient has an allergy, sensitivity, or intolerance to beta-lactam/penicillin antibiotics, cephalosporin medications, or aminoglycosides
N (No)	There is no documentation that the patient has an allergy, sensitivity, or intolerance to beta-lactam/penicillin antibiotics, cephalosporin medications or aminoglycosides or unable to determine from medical record documentation.

Notes for Abstraction: ***This question should only be answered if "Other" was selected as the prophylactic antibiotic.***

If the patient was noted to be allergic to "cillins," "penicillin," or "all cillins," select "Yes."

If one source in the record documents "Allergies: penicillin" and another source in the record documents "penicillin causes upset stomach," select "Yes."

If a physician/advanced practice nurse/physician assistant (physician/APN/PA) documents a specific reason not to give penicillin, beta-lactams, cephalosporins, or aminoglycosides, select "Yes."

Suggested Data Sources:
Consultation notes
History and physical
Medication administration record (MAR)
Nursing admission assessment
Nursing notes
Physician orders
Progress notes

Guidelines for Abstraction:

Inclusions		Exclusion
Symptoms include: Adverse effect Adverse reaction Anaphylaxis Anaphylactic reaction	Hives Rash Refer to Appendix C, Table 4.0, Antibiotic Allergy Table	None

Data Element Name: *Maternal Delivery Diagnosis Code*

Collected For: MAT-1

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code associated with maternal delivery that makes this record eligible for the MAT-1 measure.

Suggested Data Collection Question: What is the maternity delivery ICD-9-CM diagnosis code assigned to this record that makes it eligible for the MAT-1 measure?

Format:
Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ICD-9-CM diagnosis code in Tables 4.01 through 4.04 in Appendix A of the Specifications Manual for National Hospital Quality Measures.

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face sheet

Guidelines for Abstraction:

Inclusions	Exclusion
Refer to Appendix A, Tables 4.01 through 4.04 in the Specifications Manual for National Hospital Quality Measures for a list of valid ICD-9-CM codes.	None

Data Element Name: *Maternal Delivery Procedure Code*

Collected For: MAT-2

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure code associated with Cesarean section.

Suggested Data Collection Question: What is the maternity delivery ICD-9-CM procedure code assigned to this record that makes it eligible for the MAT-2 measure?

Format:
Length: 5 (implied decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ICD-9-CM procedure code listed on Inclusion list below.

Notes for Abstraction: None

Suggested Data Sources: Discharge summary
Face Sheet

Guidelines for Abstraction:

Inclusions	Exclusion
ICD-9-CM Procedure codes: 74.0 74.1 74.2 74.4 74.99	None

Data Element Name: **"***Other" Antibiotic Documented for Prophylaxis*

Collected For: MAT-1, MAT-2

Definition: Documentation that an antibiotic, other than one identified for the measure, was used for prophylaxis.

Suggested Data Collection Question: Is there documentation that the antibiotic administered was used specifically for prophylaxis?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the antibiotic administered was specifically used for prophylaxis in context to the measure.
N (No)	There is no documentation that the antibiotic administered was specifically used for prophylaxis in context to the measure.

Notes for Abstraction: ***This question should only be answered if "Other" was selected as the prophylactic antibiotic.***

Suggested Data Sources: History and physical
Physician notes
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Other IV Antibiotics (MAT-1)*

Collected For: MAT-1

Definition: Documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, Clindamycin, Erythromycin, Penicillin, or Vancomycin for GBS prophylaxis.

Suggested Data Collection Question: Is there documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, Clindamycin, Erythromycin, Penicillin, or Vancomycin for GBS prophylaxis?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, Clindamycin, Erythromycin, Penicillin, or Vancomycin for GBS prophylaxis.
N (No)	There is no documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, Clindamycin, Erythromycin, Penicillin, or Vancomycin for GBS prophylaxis or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Discharge summary
Medication administration record (MAR)
Labor and delivery flowsheets
Labor and delivery summary
Nurses notes
Physician notes
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Other IV Antibiotics – MAT-2*

Collected For: MAT-2

Definition: Documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, or Gentamycin for Cesarean section surgical prophylaxis.

Suggested Data Collection Question: Is there documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, or Gentamycin for Cesarean section surgical prophylaxis?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin, or Gentamycin for Cesarean section surgical prophylaxis.
N (No)	There is no documentation that the patient received an IV antibiotic other than Ampicillin, Cefazolin or Gentamycin for Cesarean section surgical prophylaxis or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Discharge summary
Medication administration record (MAR)
Labor and delivery flowsheets
Labor and delivery summary
Nurses notes
Physician notes
Physician orders

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Other Surgeries*

Collected For: MAT-2

Definition: Documentation of other procedures requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay.

Suggested Data Collection Question: Is there documentation of any other procedures requiring general or spinal anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation of another procedure requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay.
N (No)	There is no documentation of any other procedure requiring general or spinal/epidural anesthesia that occurred within three days prior to or after the principal procedure during this hospital stay or unable to determine from medical record documentation.

Notes for Abstraction: The following are two scenarios that must be clarified:

- If multiple procedures are performed during the **same surgical episode**, select "No."
- If other procedures are performed during **separate surgical episodes** requiring general or spinal/epidural anesthesia and occur within three days of the principal procedure during this hospital stay, select "Yes."

Suggested Data Sources:
Admitting physician orders
Admitting progress notes
Consultation notes
Discharge summary
Emergency department record
History and physical
Nursing notes
Operative notes/reports
Physician admission notes
Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Payer Source (DHCFP)*

Collected For: All MassHealth Records

Definition: Source of payment for services provided to the patient as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: What is the DHCFP assigned Payer Source code?

Format:
Length: 3
Type: Alphanumeric
Occurs: 1

Allowable Values:
103 Medicaid - includes MassHealth
104 Medicaid Managed Care - Primary Care Clinician (PCC) Plan

Notes for Abstraction:

The MassHealth population covered by the Acute Hospital RFA are those members where Medicaid is the primary payer, or when no other insurance is present.

Members enrolled in any of the four MassHealth managed care plans are excluded.

The Massachusetts Medicaid payer code definitions used by the Division of Healthcare Finance and Policy (DHCFP) differ slightly from the national hospital quality reporting. Hospitals must use the DHCFP Medicaid payer source codes when preparing the MassHealth payer data files for submission.

Suggested Data Sources: Face sheet (Emergency Department / Inpatient)

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Planned Cesarean Delivery*

Collected For: MAT-1

Definition: Documentation that a Cesarean delivery was planned for this patient in the absence of labor or membrane rupture.

Suggested Data Collection Question: Is there documentation that a planned Cesarean delivery was performed in the absence of labor or membrane rupture?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that a planned Cesarean delivery was performed for the patient in the absence of labor or membrane rupture.
N (No)	There is no documentation that a planned Cesarean delivery was performed for the patient in the absence of labor or membrane rupture or unable to determine form medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
Delivery note
Discharge summary
History and physical
Pre-natal records
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Postal Code*

Collected For: All MassHealth Records

Definition: The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question: What is the postal code of the patient's residence?

Format:
Length: 9
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "Non-US."

Notes for Abstraction: If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources: Face sheet
Social service notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Pre-natal Antibiotics for Infection (Non-GBS)*

Collected For: MAT-1

Definition: Documentation that the patient received ***intravenous*** antibiotics for a pre-natal infection other than GBS ***during the intrapartum period***.

Suggested Data Collection Question: Is there documentation the patient had a prenatal infection (not GBS) and received an ***intravenous*** antibiotic ***during the intrapartum period***?

Format:

Length:	1
Type:	Alpha
Occurs:	1

Allowable Values:

Y (Yes)	There is documentation that the patient had a prenatal infection (not GBS) and received an ***intravenous*** antibiotic.
N (No)	There is no documentation that the patient had a prenatal infection (not GBS) and received an ***intravenous*** antibiotic or unable to determine from medical record documentation.

Notes for Abstraction:

Intrapartum is defined as during labor and delivery or childbirth.

Do not select "Yes" for intravenous antibiotics administered prior to the birth admission.

Do not select "Yes" for intravenous antibiotics administered during a labor that does not end in birth.

Suggested Data Sources: Discharge summary
History and physical
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Previous Infant with Invasive GBS*

Collected For: MAT-1

Definition: Documentation that the patient delivered a previous infant with invasive GBS disease.

Suggested Data Collection Question: Is there documentation that the patient delivered a previous infant with invasive GBS disease?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	There is documentation that the patient delivered a previous infant with invasive GBS disease.
N (No)	There is no documentation that the patient delivered a previous infant with invasive GBS disease or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources: History and physical
Prenatal record
Physician progress note

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Provider ID*

Collected For: All MassHealth Records

Definition: ***The provider's seven digit acute care Medicaid or six digit Medicare provider identifier.***

Suggested Data Collection Question: ***What is the provider's seven digit acute care Medicaid or six digit Medicare provider identifier?***

Format:
Length: ***7***
Type: Alphanumeric
Occurs: 1

Allowable Values: ***Any valid seven digit Medicaid or six digit Medicare provider ID.***

Notes for Abstraction: ***When abstracting this data element for a crosswalk file, the data in this field must match the provide ID number submitted in the corresponding clinical measure file.***

Suggested Data Sources: ***Administrative record***

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Provider Name*

Collected For: All MassHealth Records

Definition: The name of the provider of acute care inpatient services.

Suggested Data Collection Question: What is the name of the provider of acute care inpatient services?

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Provider name.

Notes for Abstraction: The provider name is the name of the hospital.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Race (DHCFP)*

Collected For: All MassHealth Records

Definition: Documentation of the patient's ***self-reported*** race as defined by the Massachusetts DHCFP regulations.

Suggested Data Collection Question: ***What is the patient's self-reported race?***

Format:

Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values:

Select one:

Code	***Allowable Values***
R1	American Indian or Alaska Native:
R2	Asian:
R3	Black / African American:
R4	Native Hawaiian or other Pacific Islander:
R5	White.
R9	Other Race:
UNKNOW	Unknown / not specified:

The Massachusetts DHCFP codes and allowable values for race listed above differ significantly from ones required for National Hospital Quality Measures reporting. Hospitals must use the DHCFP race codes and allowable valuables when preparing all MassHealth data files for submission.

Notes for Abstraction: ***Only collect race data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.***

If the medical record contains conflicting documentation on patient self-reported race, abstract the most recent dated documentation.

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the DHCFP requirements must be provided for chart validation.

Suggested Data Sources: ***Administrative records***
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusions	Exclusion
• **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American. • **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • **Black / African American:** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro", can be used in addition to "Black or African American". • **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White. • **Other Race:** A person having an origin other than what has been listed above. • **Unknown:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).	None

Data Element Name: *RID Number*

Collected For: All MassHealth Records

Definition: The patient's MassHealth recipient identification number.

Suggested Data Collection Question: What is the patient's MassHealth recipient identification number?

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid recipient identification (RID) number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The abstractor should **not** assume that the claim information for the patient's RID number is correct. If the abstractor determines through chart review that the RID number is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct RID number through chart review, she/he should default to the RID number on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sample*

Collected For: All MassHealth Records

Definition: Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:

Y (Yes)	The data represents part of a sample.
N (No)	The data is not part of a sample; this indicates the hospital is abstracting 100 percent of the discharges eligible for this topic.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sex*

Collected For: All MassHealth Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What was the patient's sex on arrival?

Format:
Length: 1
Type: Alpha
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction: ***Consider the sex to be unable to determine and select "Unknown" if:***

- ***The patient refuses to provide their sex***
- ***Documentation is contradictory***
- ***Documentation indicates the patient is a transsexual***
- ***Documentation indicates the patient is a hermaphrodite***

Suggested Data Sources:
Consultation notes
Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Social Security Number*

Collected For: All MassHealth Records

Definition: The social security number (SSN) assigned to the patient.

Suggested Data Collection Question: What is the patient's social security number?

Format:
Length: 9 (no dashes)
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid social security number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction: The abstractor should **not** assume that the claim information for the social security number is correct. If the abstractor determines through chart review that the social security number is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct social security number through chart review, she/he should default to the social security number on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet
Registration form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None